-

Origination: October 2012
Last Review: October 24, 2024
Next Review: October 24, 2025
Effective Date: February 01, 2025

Description

Vermont law (26 V.S.A. § 3401(1)) defines

(1) "Acupuncture" or the "practice of acupuncture" as the insertion of fine needles through the skin at certain points on the body, with or without the application of electric current or the application of heat to the needles or skin, or both, for the purpose of promoting health and well-being or to prevent or alleviate pain or unease.

Vermont law § 3401a Scope of Practice

(a.) A licensed acupuncturist may, in addition to the practice of acupuncture employing fine needles, in a manner consistent with acupuncture theory, employ electrical, magnetic, thermal, and mechanical skin stimulation techniques; nonlaboratory diagnostic techniques; nutritional, herbal, and manual therapies; exercise and lifestyle counseling; acupressure; and massage.

(b.) A licensed acupuncturist shall not offer diagnosis of any human pathology except for a functional diagnosis, based upon the physical complaint of a patient or acupuncture theory, for purposes of developing and managing a plan of acupuncture care, or as necessary to document to insurers and other payers the reason a patient sought care.

Policy & Guidelines

Policy Statement

Effective with dates of service on or after October 2012, Blue Cross and Blue Shield of Vermont (Blue Cross VT) will allow payment for acupuncture services as eligible for payment to the extent the services follow the guidelines set forth in the payment policy.

This policy enforces the code descriptions for acupuncture services (Table 1), describes documentation requirements, and when other service codes such as evaluation and management (E/M) codes (Table 2) may be billed in conjunction with an acupuncture service.

Eligible

Per 2024 CPT ® Guidelines:

> ***Acupuncture is reported based on 15-minute increments of personal (face-to-face) contact with the patient, not the duration of acupuncture needle(s) placement.***
>
> ***If no electrical stimulation is used during a 15-minute increment, use codes 97810, 97811. If electrical stimulation of any needle is used during a 15-minute increment, use 97813, 97814.***
>
> ***Only one code may be reported for each 15-minute increment. Use either 97810 or 97813 for the initial 15-minute increment. Only one initial code is reported per day.***
>
> ***Evaluation and management services may be reported in addition to acupuncture procedures, when performed by a physicians or other health care professionals who may report evaluation ana management (E/M) services, including new or established patient office or other outpatient services. , separately using the modifier - 25 if the patient's condition requires a significant, separately identifiable E/M service above and beyond the usual preservice and post service work associated with the acupuncture services. The time of the E/M service is not included in the acupuncture service.***

Not Eligible

The cost of the needles is included in the acupuncture service and claims for such costs will be denied if submitted in addition to the acupuncture service.

Provider Billing Guidelines and Documentation

NOTE: For additional guidance refer to Blue Cross VT Provider Handbook.

Section 6.7 Claim Specific Guidelines

- Acupuncture

The following should be documented for all acupuncture services rendered:

- Brief account of chief complaints and results of the previous treatment and any significant changes that have occurred since the last visit, if applicable.
- The acupuncture points used.
- Patient positioning.
- Whether electrical stimulation was used.
- Members response to treatment.
- Progress made (or lack thereof). Note that when Functional Outcome Measures (FOM) are used, they should demonstrate Minimal Clinically Important Difference (MCID) from baseline results through periodic reassessments. If the maximum therapeutic benefit has been reached, this should be documented, and treatment should be stopped.
- Treatment plan, which should:
    - Be individualized with therapeutic goals that are functionally oriented, realistic, measurable, and evidence-based;
    - Document frequency and duration of service;
    - Be appropriately correlated with clinical findings and clinical evidence; and
    - Be expected to result in significant therapeutic improvement over a clearly defined period of time and identify a proposed date of release/discharge from treatment.

I. Other Services Provided with Acupuncture Services

Acupuncture services may be rendered by a provider who holds only an acupuncturist license or by a provider who holds an acupuncturist license and another license, or by a provider for whom the practice of acupuncture is within the scope of his or her license. As such, there may be circumstances where it is appropriate for a provider to bill acupuncture service codes and other types of service codes.

a. Electrical Stimulation

Electrical stimulation services should not be reported separately in addition to specific acupuncture services that include electrical stimulation (i.e., 97813, 97814). A modifier may be appropriate when an electrical stimulation service is performed distinctly and separate from the acupuncture service, the documentation supports the service was not related to the acupuncture, and the provider is qualified to render the service.

b. Evaluation and Management Services

Blue Cross VT expects providers to use the E/M codes listed in (Table 2). The appropriate code choice depends on whether the member is new or established, and either the level of medical decision-making or time spent on the date of the encounter.

c. Other Services within the Scope of Practice for MD/ND

Plan recognizes that providers may have more than one specialty. Providers who have an acupuncture taxonomy code and another specialty taxonomy code should bill for services using the acupuncture taxonomy code if the intent of the visit is for acupuncture only.

Benefit Determination Guidance

Payment for services is determined by the member's benefits. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Eligible services are subject to applicable member cost sharing such as co-payments, co-insurance, and deductible.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information, please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Inter Plan Programs (IPP): In accordance with the Blue Cross and Blue Shield Association's Inter-Plan Programs Policies and Provisions, this payment policy governs billing procedures for goods or services rendered by a Vermont-based provider (Blue Cross VT is the local Plan), including services rendered to out-of-state Blue members. Provider billing practices, payment policy and pricing are a local Plan responsibility that a member's Blue Plan must honor. A member's Blue Plan cannot dictate the type of claim form upon which services must be billed, codes and/or modifiers, place of service or provider type, unless it has its own direct contract with the provider (permitted only in limited situations). A member's Blue Plan cannot apply its local billing practices on claims rendered in another Plan's service area. A member's Blue Plan can only determine whether services rendered to their members are eligible for benefits. To understand if a service is eligible for payment, it is important to verify the member's benefits **prior** to providing services. In certain circumstances, the member may be financially responsible for services beyond the benefit provided for eligible services.

Claims are subject to payment edits that are updated at regular intervals and generally based on Current Procedural Terminology (CPT®), Health Care Procedural Coding System (HCPCS), Internal Classification of Diseases, CMS National Correct Coding Initiative Edits, Specialty Society guidelines, etc.

Eligible Providers

This policy applies to all providers/facilities contracted with the Plan's Network

(participating/in- network) and any non-participating/out-of-network providers/facilities.

Audit Information

Blue Cross VT reserves the right to conduct audits on any provider and/or facility to ensure adherence with the guidelines stated in the payment policy. If an audit identifies instances of non-adherence with this payment policy, Blue Cross VT reserves the right to recover all non-adherence payments.

Legislative and Regulatory Guidelines

Vermont 26 V.S.A. § 3401(1)

Vermont § 3401a

Related Policies

N/A

References

American Medical Association. (*2024). CPT®: Current Procedural Terminology (Professiona*l). Chicago IL: American Medical Association.

Document Precedence

The Blue Cross VT Payment Policy Manual was developed to provide guidance for providers regarding Blue Cross VT payment practices and facilitates the systematic application of Blue Cross VT member contracts and employer benefit documents, provider contracts, Blue Cross VT corporate medical policies, and Plan's claim editing logic. Document precedence is as follows:

1) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the member contracts or employer benefit documents, the member contract or employer benefit document language takes precedence.
2) To the extent that there may be any conflict between the Blue Cross VT Payment

Policy Manual and provider contract language, the provider contract language takes precedence.

3) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and corporate medical policy, the corporate medical policy takes precedence.

4) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the Plan's claim editing solutions, the Plan's claim editing solution takes precedence.

Policy Implementation/Update Information

This policy was originally implemented October 01, 2012.

Date of Change	Effective Date	Overview of Change
		Original Date October 01. 2012.
October 24, 2024	February 1, 2025	Payment policy updated new template format, references and regulatory guidelines added. Minor editorial refinements to policy statements; intent unchanged.

Approved by **Update Approved: 10/24/2024**

Tom Weigel, MD, Chief Medical Officer

Table I (Acupuncture Codes)

Code	Description
97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
97811	Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with insertion of needle(s) (list separately in addition to code for primary procedure)
97813	Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
97814	Acupuncture, 1 or more needles, with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with insertion of needle(s) (list separately in addition to code for primary procedure)

Table 2 (E/M Codes)

Code	Description
99202	New Patient – Level 2
99203	New Patient – Level 3
99204	New Patient – Level 4
99205	New Patient – Level 5
99211	Established Patient – Level 1
99212	Established Patient – Level 2
99213	Established Patient – Level 3
99214	Established Patient – Level 4
99215	Established Patient – Level 5